

Facility Name & ID Number Vandalia Rehabilitation & Health Care Center

0047589 Report Period Beginning: 1/1/2008 Ending: 12/31/2008

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>57</u>	Skilled (SNF)	<u>57</u>	<u>20,862</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>59</u>	Intermediate (ICF)	<u>59</u>	<u>21,594</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>116</u>	TOTALS	<u>116</u>	<u>42,456</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF			<u>2,435</u>	<u>2,435</u>	8
9	SNF/PED					9
10	ICF	<u>12,246</u>	<u>2,531</u>		<u>14,777</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>12,246</u>	<u>2,531</u>	<u>2,435</u>	<u>17,212</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 40.54%

D. How many bed-hold days during this year were paid by the Department? None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES NO Non-allowable costs have been eliminated in Schedule V, Column 7

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES NO

I. On what date did you start providing long term care at this location?
Date started 10/01/2005

J. Was the facility purchased or leased after January 1, 1978?
YES Date 10/01/2005 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 57 and days of care provided 2,435

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES NO

Tax Year: 12/31/2008 Fiscal Year: 12/31/2008

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Vandalia Rehabilitation & Health Care Center # 0047589 Report Period Beginning: 1/1/2008 Ending: 12/31/2008

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	123,971	9,850		133,821		133,821	3,059	136,880		1
2	Food Purchase		97,286		97,286		97,286	(4,774)	92,512		2
3	Housekeeping	58,526	18,590		77,116		77,116	23	77,139		3
4	Laundry	41,281	8,979		50,260		50,260	1	50,261		4
5	Heat and Other Utilities			91,207	91,207		91,207	317	91,524		5
6	Maintenance	34,285	11,310	28,811	74,406		74,406	2,810	77,216		6
7	Other (specify):* <u>Home Off. Ben. All.</u>							1,042	1,042		7
8	TOTAL General Services	258,063	146,015	120,018	524,096		524,096	2,478	526,574		8
	B. Health Care and Programs										
9	Medical Director			8,800	8,800		8,800		8,800		9
10	Nursing and Medical Records	747,586	83,517	2,840	833,943		833,943	4,034	837,977		10
10a	Therapy		95	268,204	268,299		268,299		268,299		10a
11	Activities	23,914	287	521	24,722		24,722		24,722		11
12	Social Services	21,992	150	95	22,237		22,237	8	22,245		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* <u>Home Off. Ben. All.</u>							927	927		15
16	TOTAL Health Care and Programs	793,492	84,049	280,460	1,158,001		1,158,001	4,969	1,162,970		16
	C. General Administration										
17	Administrative	71,154		151,000	222,154		222,154	(125,316)	96,838		17
18	Directors Fees										18
19	Professional Services			12,572	12,572		12,572	5,099	17,671		19
20	Dues, Fees, Subscriptions & Promotions			8,224	8,224		8,224	870	9,094		20
21	Clerical & General Office Expenses	34,475	5,054	17,335	56,864		56,864	34,246	91,110		21
22	Employee Benefits & Payroll Taxes			151,484	151,484		151,484		151,484		22
23	Inservice Training & Education			721	721		721	194	915		23
24	Travel and Seminar							194	194		24
25	Other Admin. Staff Transportation			4,979	4,979		4,979	6,702	11,681		25
26	Insurance-Prop.Liab.Malpractice			22,260	22,260		22,260	143	22,403		26
27	Other (specify):* <u>Home Off. Ben. All.</u>							9,829	9,829		27
28	TOTAL General Administration	105,629	5,054	368,575	479,258		479,258	(68,039)	411,219		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,157,184	235,118	769,053	2,161,355		2,161,355	(60,592)	2,100,763		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number

Vandalia Rehabilitation & Health Care Center

#0047589

Report Period Beginning:

1/1/2008

Ending:

12/31/2008

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			49,991	49,991		49,991	(1,037)	48,954			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			42,666	42,666		42,666	10,366	53,032			32
33	Real Estate Taxes			35,643	35,643		35,643	437	36,080			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			35,253	35,253		35,253	372	35,625			35
36	Other (specify):*											36
37	TOTAL Ownership			163,553	163,553		163,553	10,138	173,691			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		105,227		105,227		105,227		105,227			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			63,684	63,684		63,684		63,684			42
43	Other (specify):* Non-allowable Cost		1,258	147,906	149,164		149,164	(149,164)				43
44	TOTAL Special Cost Centers		106,485	211,590	318,075		318,075	(149,164)	168,911			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,157,184	341,603	1,144,196	2,642,983		2,642,983	(199,618)	2,443,365			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Vandalia Rehabilitation & Health Care Center

ID# 0047589

Report Period Beginning: 1/1/2008

Ending: 12/31/2008

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (6,687)	43	1
2	X-Rays-Part A	(2,121)	43	2
3	Offset Miscellaneous Nursing Supplies Revenue	(1,276)	10	3
4	Offset Miscellaneous Food Revenue	(4,827)	2	4
5	Offset Miscellaneous Office Supplies Revenue	(264)	21	5
6	Resident Flowers	(438)	43	6
7	Disallowed Special Events	(1,300)	43	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(16,913)		49

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Mark Petersen	100	See Attached Schedule 6E		See Attached Sch 6E		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	1 Dietary	\$	Petersen Health Care, Inc.	100.00%	\$ 3,059	\$ 3,059	1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	50	50	2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	23	23	3
4	V	4 Laundry		Petersen Health Care, Inc.	100.00%	1	1	4
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	317	317	5
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	1,870	1,870	6
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	752	752	7
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	5,310	5,310	8
9	V	11 Activities		Petersen Health Care, Inc.	100.00%	0		9
10	V	15 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	927	927	10
11	V	17 Administrative	151,000	Petersen Health Care, Inc.	100.00%	23,816	(127,184)	11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	2,688	2,688	12
13	V							13
14	Total		\$ 151,000			\$ 38,813	\$ * (112,187)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	20 Dues, Fees, Subs and Promotions	\$	Petersen Health Care, Inc.	100.00%	\$ 829	\$	829	15
16	V	21 Clerical and General Office		Petersen Health Care, Inc.	100.00%	29,887		29,887	16
17	V	23 Inservice Training and Education		Petersen Health Care, Inc.	100.00%	182		182	17
18	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	182		182	18
19	V	25 Other Admin. Staff Transportation		Petersen Health Care, Inc.	100.00%	2,353		2,353	19
20	V	26 Insurance-Prop./Liab/Malpractice		Petersen Health Care, Inc.	100.00%	143		143	20
21	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	8,509		8,509	21
22	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	3,256		3,256	22
23	V	32 Interest		Petersen Health Care, Inc.	100.00%	2,290		2,290	23
24	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	437		437	24
25	V	34 Rent-Facility and Grounds		Petersen Health Care, Inc.	100.00%	0			25
26	V	35 Rent-Equipment and Vehicles		Petersen Health Care, Inc.	100.00%	372		372	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$			\$ 48,440	\$ *	48,440	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Vandalia Rehabilitation & Health Care Center# 0047589Report Period Beginning: 1/1/2008Ending: 12/31/2008

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	1 Dietary	\$	Petersen Health Operations, LLC	100.00%	\$ 0	\$	15	
16	V	2 Food		Petersen Health Operations, LLC	100.00%	3	3	16	
17	V	3 Housekeeping		Petersen Health Operations, LLC	100.00%	0		17	
18	V	4 Laundry		Petersen Health Operations, LLC	100.00%	0		18	
19	V	5 Utilities		Petersen Health Operations, LLC	100.00%	0		19	
20	V	6 Maintenance		Petersen Health Operations, LLC	100.00%	940	940	20	
21	V	7 Mgmt. Allocation of Benefits		Petersen Health Operations, LLC	100.00%	290	290	21	
22	V	10 Nursing and Medical Records		Petersen Health Operations, LLC	100.00%	0		22	
23	V	12 Social Services		Petersen Health Operations, LLC	100.00%	8	8	23	
24	V	17 Administrative		Petersen Health Operations, LLC	100.00%	1,868	1,868	24	
25	V	19 Professional Services		Petersen Health Operations, LLC	100.00%	2,411	2,411	25	
26	V	20 Dues, Fees, Subs & Promotions		Petersen Health Operations, LLC	100.00%	41	41	26	
27	V	21 Clerical and General Office		Petersen Health Operations, LLC	100.00%	4,623	4,623	27	
28	V	22 Employee Benefits & Payroll		Petersen Health Operations, LLC	100.00%	0		28	
29	V	23 Inservice Training & Education		Petersen Health Operations, LLC	100.00%	12	12	29	
30	V	24 Travel and Seminar		Petersen Health Operations, LLC	100.00%	12	12	30	
31	V	25 Other Admin. Staff Transport.		Petersen Health Operations, LLC	100.00%	4,349	4,349	31	
32	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Operations, LLC	100.00%	0		32	
33	V	27 Mgmt. Allocation of Benefits		Petersen Health Operations, LLC	100.00%	1,320	1,320	33	
34	V	30 Depreciation		Petersen Health Operations, LLC	100.00%	1,069	1,069	34	
35	V	32 Interest		Petersen Health Operations, LLC	100.00%	8,720	8,720	35	
36	V	33 Real Estate Taxes		Petersen Health Operations, LLC	100.00%	0		36	
37	V	34 Rent-Facility and Grounds		Petersen Health Operations, LLC	100.00%	0		37	
38	V	35 Rent-Equipment & Vehicles		Petersen Health Operations, LLC	100.00%	0		38	
39	Total		\$			\$ 25,666	\$ *	25,666	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Vandalia Rehabilitation & Health Care Cent # 0047589 Report Period Beginning: 1/1/2008 Ending: 12/31/2008

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Mark Petersen	President	Administrative	100.00	1,804,858	0.71	1.19	Salary	23,816	L17, C7	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 23,816		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Vandalia Rehabilitation & Health Care Center# 0047589

Report Period Beginning:

1/1/2008Ending: 2/31/2008

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

Name of Related Organization

Petersen Health Care, Inc.

Street Address

830 W. Trailcreek Drive

City / State / Zip Code

Peoria, IL 61614

Phone Number

(309) 691-8113

Fax Number

(309) 691-8622

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Resident Days	1,413,604	69	\$ 251,260	\$ 250,687	17,212	\$ 3,059	1
2	2	Food	Resident Days	1,413,604	69	4,125	0	17,212	50	2
3	3	Housekeeping	Resident Days	1,413,604	69	1,859	0	17,212	23	3
4	4	Laundry	Resident Days	1,413,604	69	110	0	17,212	1	4
5	5	Utilities	Resident Days	1,413,604	69	26,036	0	17,212	317	5
6	6	Maintenance	Resident Days	1,413,604	69	153,551	100,245	17,212	1,870	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,413,604	69	61,774	0	17,212	752	7
8	10	Nursing and Medical Records	Resident Days	1,413,604	69	436,084	432,530	17,212	5,310	8
9	10A	Therapy	Resident Days	1,413,604	69	0	0	17,212	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,413,604	69	76,136	0	17,212	927	10
11	17	Administrative	Resident Days	1,413,604	69	1,955,999	1,956,000	17,212	23,816	11
12	19	Professional Services	Resident Days	1,413,604	69	220,762	0	17,212	2,688	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,413,604	69	68,094	0	17,212	829	13
14	21	Clerical and General Office	Resident Days	1,413,604	69	2,454,596	2,013,896	17,212	29,887	14
15	23	Inservice Training & Education	Resident Days	1,413,604	69	14,912	0	17,212	182	15
16	24	Travel and Seminar	Resident Days	1,413,604	69	14,938	0	17,212	182	16
17	25	Other Admin. Staff Transport.	Resident Days	1,413,604	69	193,264	0	17,212	2,353	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,413,604	69	11,767	0	17,212	143	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,413,604	69	698,810	0	17,212	8,509	19
20	30	Depreciation	Resident Days	1,413,604	69	267,426	0	17,212	3,256	20
21	32	Interest	Resident Days	1,413,604	69	188,107	0	17,212	2,290	21
22	33	Real Estate Taxes	Resident Days	1,413,604	69	35,872	0	17,212	437	22
23	34	Rent-Facility and Grounds	Resident Days	1,413,604	69	0	0	17,212	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,413,604	69	30,580	0	17,212	372	24
25	TOTALS					\$ 7,166,062	\$ 4,753,358		\$ 87,253	25

Facility Name & ID Number Vandalia Rehabilitation & Health Care Center

0047589

Report Period Beginning:

1/1/2008

Ending: 2/31/2008

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

Name of Related Organization Petersen Health Operations, LLC
 Street Address 830 W. Trailcreek Drive
 City / State / Zip Code Peoria, IL 61614
 Phone Number (309) 691-8113
 Fax Number (309) 691-8622

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Resident Days	419,957	23	\$	17,212	\$	1	
2	2	Food	Resident Days	419,957	23	68	17,212	3	2	
3	3	Housekeeping	Resident Days	419,957	23		17,212		3	
4	4	Laundry	Resident Days	419,957	23		17,212		4	
5	5	Utilities	Resident Days	419,957	23		17,212		5	
6	6	Maintenance	Resident Days	419,957	23	22,929	10,000	17,212	940	6
7	7	Mgmt. Allocation of Benefits	Resident Days	419,957	23	7,067		17,212	290	7
8	10	Nursing and Medical Records	Resident Days	419,957	23	6		17,212		8
9	12	Social Services	Resident Days	419,957	23	187		17,212	8	9
10	17	Administrative	Resident Days	419,957	23	45,582	45,582	17,212	1,868	10
11	19	Professional Services	Resident Days	419,957	23	58,812		17,212	2,411	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	419,957	23	997		17,212	41	12
13	21	Clerical and General Office	Resident Days	419,957	23	112,798		17,212	4,623	13
14	22	Employee Benefits & Payroll	Resident Days	419,957	23			17,212		14
15	23	Inservice Training & Education	Resident Days	419,957	23	299		17,212	12	15
16	24	Travel and Seminar	Resident Days	419,957	23	296		17,212	12	16
17	25	Other Admin. Staff Transport.	Resident Days	419,957	23	106,105		17,212	4,349	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	419,957	23			17,212		18
19	27	Mgmt. Allocation of Benefits	Resident Days	419,957	23	32,211		17,212	1,320	19
20	30	Depreciation	Resident Days	419,957	23	26,070		17,212	1,069	20
21	32	Interest	Resident Days	419,957	23	212,765		17,212	8,720	21
22	33	Real Estate Taxes	Resident Days	419,957	23			17,212		22
23	34	Rent-Facility and Grounds	Resident Days	419,957	23			17,212		23
24	35	Rent-Equipment & Vehicles	Resident Days	419,957	23			17,212		24
25	TOTALS					\$ 626,192	\$ 55,582		\$ 25,666	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	Bank of America		X	Mortgage	Varies	01/19/07	\$ 657,483	\$ 645,397	12/31/13	Varies	\$ 42,666	1								
2												2								
3							Interest Income Offset				(644)	3								
4							Home Office Allocation-PHC				2,290	4								
5							Home Office Allocation-PHO				8,720	5								
Working Capital																				
6												6								
7												7								
8												8								
9	TOTAL Facility Related						\$ 657,483	\$ 645,397			\$ 53,032	9								
B. Non-Facility Related*																				
10												10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$	14								
15	TOTALS (line 9+line14)						\$ 657,483	\$ 645,397			\$ 53,032	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2007 report.		\$	35,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2007	\$	34,643	2
3. Under or (over) accrual (line 2 minus line 1).		\$	(357)	3
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	36,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. Home Office Allocation			437	
TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	36,080	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2003	_____	8
	2004	_____	9
	2005	30,105	10
	2006	33,715	11
	2007	34,643	12

Accrual based on prior year tax bill.

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2007	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2007 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2008 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2007 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Vandalia Rehabilitation & Health Care Center COUNTY Fayette

FACILITY IDPH LICENSE NUMBER 0047589

CONTACT PERSON REGARDING THIS REPORT Mark Petersen

TELEPHONE (309) 691-8113 FAX #: (309) 691-8622

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2007 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2007.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>18-14-17-453-012</u>	<u>Long-Term Care Facility</u>	\$ <u>34,643.49</u>	\$ <u>34,643.49</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>34,643.49</u>	\$ <u>34,643.49</u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

PLEASE NOTE: Payment information from the Internet or otherwise is not considered acceptable tax bill documentation. Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 20,764 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>159,430</u>	<u>2005</u>	<u>\$ 29,250</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	159,430		\$ 29,250	3

Facility Name & ID Number **Vandalia Rehabilitation & Health Care Center**

0047589

Report Period Beginning:

1/1/2008

Ending:

12/31/2008

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	116	2005	1969	\$ 527,250	\$	25	\$ 21,090	\$ 21,090	\$ 73,815	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Original Land Improvements		2005	13,000		15	867	867	3,034	9
10	Sidewalks		2006	7,967		15	531	531	1,328	10
11	Water Heater		2007	7,681		15	512	512	768	11
12	Interior Signage		2007	1,795		10	180	180	270	12
13	Air Conditioner		2007	5,800		15	387	387	580	13
14	Carpeting		2007	4,617		10	462	462	693	14
15	Electrical Panel Repair		2008	2,600		7	186	186	186	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25										25
26										26
27										27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36										36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44			21,155			(21,155)		44
45			5,319			(5,319)		45
46								46
47								47
48		598			39	39		48
49		8,937			214	214		49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70		\$ 580,245	\$ 26,474		\$ 24,468	\$ (2,006)	\$ 80,674	70

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 139,226	\$ 22,002	\$ 19,330	\$ (2,672)	7-10 yrs.	\$ 64,917	71
72	Current Year Purchases	21,676	1,515	1,084	(431)	10 yrs.	1,084	72
73	Fully Depreciated Assets							73
74	Home Office Allocation			4,072	4,072			74
75	TOTALS	\$ 160,902	\$ 23,517	\$ 24,486	\$ 969		\$ 66,001	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 770,397	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 49,991	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 48,954	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (1,037)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 146,675	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88	N/A				88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93	N/A		93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 13,655 Description: See Attached Schedule 14A

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility	2006 Ford E250	\$ 578	\$ 21,970	17
18					18
19					19
20					20
21	TOTAL		\$ 578	\$ 21,970	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. _____ /2009 \$ _____

13. _____ /2010 \$ _____

14. _____ /2011 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Vandalia Rehabilitation & Health Care Center

0047589

Period Beginning 1/1/2008

Period End 12/31/2008

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Medical Equipment	\$ 9,724
Dishwasher	622
Laundry Equipment	59
Copier	2,878
Home Office Allocation	372
	<u>13,655</u>

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>It is the policy of this facility to only hire certified nurses aides. If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A(3)	hrs	\$	456	\$ 109,517	\$	456	\$ 109,517	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		69	16,758		69	16,758	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(2), 10A(3)	hrs		590	141,489	95	590	141,584	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				105,227		105,227	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): _____									12
13	Other (specify): <u>Respiratory Therapy</u>	10A(3)				440			440	13
14	TOTAL			\$	1,115	\$ 268,204	\$ 105,322	1,115	\$ 373,526	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Vandalia Rehabilitation & Health Care Center

0047589

Report Period Beginning: 1/1/2008

Ending: 12/31/2008

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2008

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ (177,758)	\$ (177,758)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance N/A)	890,641	890,641	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	28,893	28,893	6
7	Other Prepaid Expenses	8,953	8,953	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 750,729	\$ 750,729	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	50,217	29,250	13
14	Buildings, at Historical Cost	527,250	536,187	14
15	Leasehold Improvements, at Historical Cost	22,493	44,058	15
16	Equipment, at Historical Cost	160,901	160,902	16
17	Accumulated Depreciation (book methods)	(144,997)	(146,675)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 615,864	\$ 623,722	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,366,593	\$ 1,374,451	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 522,796	\$ 522,796	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	23,032	23,032	30
31	Accrued Taxes Payable (excluding real estate taxes)	6,845	6,845	31
32	Accrued Real Estate Taxes(Sch.IX-B)	36,000	36,000	32
33	Accrued Interest Payable	3,223	3,223	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Payroll Withholdings</u>	20,562	20,562	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 612,458	\$ 612,458	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	645,397	645,397	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 645,397	\$ 645,397	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,257,855	\$ 1,257,855	46
47	TOTAL EQUITY(page 18, line 24)	\$ 108,738	\$ 116,596	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,366,593	\$ 1,374,451	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 74,393	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 74,393	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	34,345	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 34,345	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 108,738	24 *

* This must agree with page 17, line 47.

**XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense**

1

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 1,945,172	1
2	Discounts and Allowances for all Levels	105,736	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,050,908	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	419,036	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 419,036	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	4,827	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	173,107	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	8,083	20
21	Other Medical Services	19,183	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 205,200	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	644	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 644	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Miscellaneous Revenue</u>	1,540	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,540	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,677,328	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	524,096	31
32	Health Care	1,158,001	32
33	General Administration	479,258	33
	B. Capital Expense		
34	Ownership	163,553	34
	C. Ancillary Expense		
35	Special Cost Centers	254,391	35
36	Provider Participation Fee	63,684	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,642,983	40
41	Income before Income Taxes (line 30 minus line 40)**	34,345	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 34,345	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation. Facility is part of larger entity.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Vandalia Rehabilitation & Health Care Center

0047589

Report Period Beginning:

1/1/2008

Ending:

12/31/2008

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,924	1,924	\$ 47,702	\$ 24.79	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,553	4,672	105,206	22.52	3
4	Licensed Practical Nurses	14,871	15,355	249,260	16.23	4
5	CNAs & Orderlies	35,019	35,871	309,785	8.64	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,979	2,051	20,524	10.01	9
10	Activity Assistants	428	428	3,390	7.92	10
11	Social Service Workers	2,080	2,080	21,992	10.57	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	34,706	16.69	13
14	Head Cook					14
15	Cook Helpers/Assistants	11,061	11,490	89,265	7.77	15
16	Dishwashers					16
17	Maintenance Workers	2,395	2,459	34,285	13.94	17
18	Housekeepers	7,296	7,606	58,526	7.69	18
19	Laundry	5,110	5,221	41,281	7.91	19
20	Administrator	2,253	2,253	71,154	31.58	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,993	1,993	34,475	17.30	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>Care Plan Coord.</u>	2,080	2,080	35,633	17.13	33
34	TOTAL (lines 1 - 33)	95,122	97,563	\$ 1,157,184 *	\$ 11.86	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	\$		35
36	Medical Director	Monthly 8,800	9(3)	36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant	Monthly 1,200	10(3)	39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant			44
45	Social Service Consultant	1 Visit 95	12(3)	45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 10,095		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	\$		50
51	Licensed Practical Nurses	N/A		51
52	Certified Nurse Assistants/Aides			52
53	TOTAL (lines 50 - 52)	\$		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount		
Shannon Paden	Administrator	0	\$ 69,000	Workers' Compensation Insurance	\$ 33,316	IDPH License Fee	\$ 1,990		
Michelle Vaughan	Administrator	0	2,154	Unemployment Compensation Insurance	39,781	Advertising: Employee Recruitment	1,094		
				FICA Taxes	86,660	Health Care Worker Background Check (Indicate # of checks performed)			
				Employee Health Insurance	(6,395)	Patient Background Checks	173 1,730		
				Employee Meals		Miscellaneous Licenses & Permits	250		
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Dues & Subscriptions	500		
				Employee Relations	83	IHCA Dues	2,660		
				Employee Retirement	494	Home Office Allocation	870		
				Uniform Withholding	(2,455)				
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 71,154	TOTAL (agree to Schedule V, line 22, col.8)		\$ 151,484	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 9,094
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description	Amount	
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 151,000				Out-of-State Travel	\$	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 151,000				In-State Travel		
C. Professional Services							Seminar Expense		
Vendor/Payee	Type		Amount				Home Office Allocation	194	
Burnside, Johnston & Assoc.	Legal Services		\$ 1,267				Entertainment Expense (agree to Sch. V, line 24, col. 8)		
E-Health Data Solutions	Computer Services		2,880				TOTAL	\$ 194	
AT&T	Computer Services		340						
LTC Solutions	Computer Services		1,600						
Heyl, Royster, Voelker & Allen	Legal Services		6,485						
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 12,572	TOTAL			\$		

* Attach copy of IMRF notifications

**See instructions.

Vandalia Rehabilitation & Health Care Center

0047589

Period Beginning 1/1/2008

Period End 12/31/2008

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		12,572

Home Office Allocation

Heyl, Royster, Voelker & Allen	Legal	197
GoffWilson, P.A.	Legal	326
Ginoli & Company	Accountants	2,731
RSM McGladrey	Accountants	7
Miscellaneous Vendors	Computer Services	38
Emdeon Business Services	Computer Services	53
Advanced Answers on Demand	Computer Services	618
Access 2 Go	Computer Services	182
Ivans	Computer Services	422
Kemper Technology	Computer Services	334
VisionShare	Computer Services	36
Logmein	Computer Services	26
Comm Net Communiations	Computer Services	9
Charter Communications	Computer Services	8
Advanced System Designs	Computer Services	12
Consolidated Communications	Computer Services	7
Miscellaneous Vendors	Miscellaneous	93

Total (agree to Schedule V, line 19, column 8)		<u>17,671</u>
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**Vandalia Rehabilitation & Health Care Center
0047589**

Period Beginning 1/1/2008

Period End 12/31/2008

XIX. SUPPORT SCHEDULES

Schedule 21B

A. Administrative Salaries

Name	Function	Ownership %	Amount
Shannon Paden	Administrator	0	69,000
Michelle Vaughan	Administrator	0	2,154
	Total		<u>71,154</u>

Facility Name & ID Number Vandalia Rehabilitation & Health Care Center# 0047589Report Period Beginning: 1/1/2008Ending: 12/31/2008**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. 2,660 -IHCA
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? No
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Yrs.
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 6,290 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? N/A
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 63,684
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 4,827
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ No
- c. What percent of all travel expense relates to transportation of nurses and patients? N/A
- d. Have vehicle usage logs been maintained? Adequate records have been maintained.
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? N/A**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ No
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Ginoli & Company The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Audit currently in progress
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees